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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **AMANDA LYNN ROBBINS** **4371 Telfair Boulevard, Apartment A101** **Camp Springs, Maryland 20746** **Registered Nurse License Number 733946** Respondent.	Case Number 2013-363 **ACCUSATION**

Complainant alleges:

PARTIES

1. Complainant Louise R. Bailey, M.Ed., R.N., brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about August 7, 2008, the Board issued Registered Nurse License Number 733946 to respondent Amanda Lynn Robbins. This registered nurse license was in full force and effect at all times relevant to the charges brought in this Accusation and will expire on March 31, 2014, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 118, subdivision (b), provides:

"The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute of continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground."

5. Section 2750 provides:

"Every certificate holder or licensee, including licensees holding temporary licenses, or licensees holding licenses placed in an inactive status, may be disciplined as provided in this article [Article 3 of the Nursing Practice Act (Bus. & Prof. Code, § 2700 et seq.)]. As used in this article, 'license' includes certificate, registration, or any other authorization to engage in practice regulated by this chapter. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code [the Administrative Procedure Act], and the board shall have all the powers granted therein."

6. Section 2764 provides:

"The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary surrender of a license by a licentiate shall not deprive the board of jurisdiction to proceed with any investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license."

STATUTORY PROVISIONS

7. Section 2761 provides, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

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"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

8. Section 2762 provides, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act] it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist adminster to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

9. California Code of Regulations, title 16, section 1442, provides:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

10. California Code of Regulations, title 16, section 1443, provides:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

11. California Code of Regulations, title 16, section 1443.5, provides:

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"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

COST RECOVERY

12. Section 125.3, subdivision (a), provides:

"Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceedings, the administrative law judge may direct a

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licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case."

DRUGS

13. Codeine-Guaifenesin is used to treat cough and reduce chest congestion. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(2), and a dangerous drug within the meaning of Business and Professions Code section 4022.

14. Fentanyl is used to treat breakthrough cancer-related pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(8), and a dangerous drug within the meaning of Business and Professions Code section 4022.

15. Hydrocodone-Acetaminophen (Vicodin) is used for the relief of moderate to moderately severe pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I), or a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(4), based on the amount of Hydrocodone contained. It is a dangerous drug within the meaning of Business and Professions Code section 4022.

16. Hydromorphone (Dilaudid) is used to treat moderate to severe pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J), and a dangerous drug within the meaning of Business and Professions Code section 4022.

17. Morphine is used to treat moderate to severe pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(L), and a dangerous drug within the meaning of Business and Professions Code section 4022.

18. Oxycodone-Acetaminophen (Percocet) is used to treat moderate to severe pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(N), and a dangerous drug within the meaning of Business and Professions Code section 4022.

19. Pyxis is a computerized management, storage, and medication dispensing system/machine manufactured by the Cardinal Health Corporation located in Dublin, Ohio. Pyxis is a medication cart/unit containing all medications used throughout a hospital. Each Pyxis

medication cart/unit is linked to the main computer maintained by the Hospital's Pharmacy Department where all Pyxis information is stored. Medical employees are given access to the Pyxis medication cart/unit via biometric identification (fingerprint scan) and password.

20. Zaleplon (Sonata) is used to treat insomnia. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(31), and a dangerous drug within the meaning of Business and Professions Code section 4022.

21. Zolpidem (Ambien) is used to treat insomnia. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(32), and a dangerous drug within the meaning of Business and Professions Code section 4022.

FACTUAL BACKGROUND

22. Respondent was employed by Stanford Hospital and Clinics in Stanford, California, as a registered nurse from about January 2007 until she resigned and was terminated on or about December 21, 2010.

23. An audit of respondent's narcotic medication withdrawals on the hospital's Pyxis system showed possible improper withdrawal and distribution of medications, and improper charting. A thorough investigation of the time periods of September 7 through October 6, 2010, and October 23 through November 22, 2010, revealed gross discrepancies and inconsistencies in patient records and the corresponding Pyxis records. Examples of these discrepancies and inconsistencies are as follows:

A. **Patient A**[1]

1) On September 29, 2010, a physician ordered 4 mg Hydromorphone every 15 minutes as needed, starting on September 29, 2010, at 9:58 a.m., and ending on October 29, 2010, at 10:07 a.m.

2) On October 24, 2010, at 9:18 p.m., respondent removed 4 mg Hydromorphone from Pyxis. At 9:19 p.m., she cancelled a transaction to remove 2 mg Hydromorphone from Pyxis. She charted the patient's pain was "8" at 9:35 p.m. At 9:36 p.m., she administered 4 mg

[1] The patients' names will be released pursuant to a discovery request.

Hydromorphone. She charted the patient's pain was "6" at 10:35 p.m.

B. **Patient B**

1) On September 14, 2010, a physician ordered 5 mg Zaleplon capsule every bedtime as needed, starting on September 14, 2010, at 12:48 a.m., and ending on September 18, 2010, at 6:55 p.m.

2) On September 17, 2010, at 11:00 p.m., respondent removed a 5 mg Zaleplon tablet from Pyxis. She did not chart administering or wasting it, or otherwise account for it.

C. **Patient C**

1) On September 17, 2010, a physician ordered 1-2 mg Morphine every 4 hours as needed, starting on September 21, 2010, at 3:34 p.m., and ending on September 27, 2010, at 3:51 p.m.

2) On September 26, 2010, at 2:00 a.m., respondent removed 2 mg Morphine from Pyxis. She wasted 1 mg of it. At 3:49 a.m., she administered 1 mg Morphine. She did not chart a pain assessment before administering it.

3) At 3:52 a.m., respondent removed 2 mg Morphine from Pyxis. She did not chart a pain assessment before removing it. She wasted 1 mg of it. She did not chart administering or wasting, or otherwise account for, the remaining 1 mg of Morphine.

4) At 3:53 a.m., respondent removed 2 mg Morphine from Pyxis. She did not chart a pain assessment before removing it. She wasted 1 mg of it. She did not chart administering or wasting, or otherwise account for, the remaining 1 mg Morphine.

5) Respondent charted the patient's pain was "0" at 4:49 a.m.

D. **Patient D**

1) On September 24, 2010, a physician started an order for Hydromorphone (PF). The order was not completed, nor did it include the dose, route, or frequency.

2) On September 24, 2010, a physician ordered 1 mg Hydromorphone every 3 hours as needed, starting on September 24, 2010, at 9:25 p.m., and ending on September 25, 2010, at 10:16 a.m.

3) On September 24, 2010, at 9:41 p.m., respondent removed 1 mg Hydromorphone

from Pyxis using an override. At 9:43 p.m., she wasted 1 mg of it. At 10:00 p.m., she charted administering 1 mg Hydromorphone at 9:42 p.m. She did not chart a pain assessment before administering it.

4) On September 24, 2010, a physician started another order for Hydromorphone (PF). The order was not completed either, nor did it include the dose, route, or frequency.

5) On September 24, 2010, at 10:00 p.m., respondent noted that this order was not given because it was "charted once already. Did give 1 mg hydromorphone."

6) At 9:44 p.m., respondent removed 1 mg Hydromorphone from Pyxis using an override. She charted the patient's pain was "5" at 11:00 p.m. On September 25, 2010, at 12:34 a.m., she "late charted" (charted unreasonably late after the act) that she administered 1 mg Hydromorphone on September 24, 2010, at 10:00 p.m. She did not record a reason for the late charting.

7) On September 25, 2010, at 12:34 a.m., respondent "early charted" (charted before the act) that she administered 1 mg Hydromorphone at 1:00 a.m. At 12:42 a.m., she removed 2 mg Hydromorphone from Pyxis. She wasted 1 mg of it. She did not chart a pain assessment before administering it. She charted the patient's pain was "5" at 2:00 a.m. She charted the patient's pain was "1" at 3:00 a.m.

8) At 3:32 a.m., respondent removed 2 mg Hydromorphone from Pyxis. She wasted 1 mg of it. At 5:19 a.m., she late charted that she administered 1 mg Hydromorphone at 4:00 a.m. She did not record a reason for the late charting. She did not chart a pain assessment after administering it.

9) On September 27, 2010, a physician ordered 0.5-1 mg Hydromorphone every 4 hours as needed, starting on September 27, 2010, at 12:43 p.m., and ending on October 1, 2010, at 6:12 p.m.

10) On September 30, 2010, at 9:06 p.m., respondent removed 2 mg Hydromorphone from Pyxis. She wasted 1 mg of it. She did not chart administering or wasting, or otherwise account for, the remaining 1 mg Hydromorphone. She did not chart a pain assessment before or after removing the Hydromorphone from Pyxis.

E. **Patient E**

1) On September 30, 2010, a physician ordered 0.5-1 mg Hydromorphone every 6 hours as needed, starting on September 30, 2010, at 3:23 a.m., and ending on September 30, 2010, at 3:53 a.m.

2) On September 30, 2010, at 3:37 a.m., respondent removed 2 mg Hydromorphone from Pyxis. She wasted 1 mg of it. She did not chart administering or wasting, or otherwise account for, the remaining 1 mg Hydromorphone. She did not chart a pain assessment before or after removing the Hydromorphone from Pyxis.

3) On September 30, 2010, a physician ordered 0.5-1 mg Hydromorphone every 6 hours as needed, starting on September 30, 2010, at 3:53 a.m., and ending on September 30, 2010, at 8:01 a.m.

F. **Patient F**

1) On October 2, 2010, a physician ordered 6-8 mg Hydromorphone every 2 hours as needed, starting on October 2, 2010, at 11:43 a.m., and ending on October 4, 2010, at 6:50 p.m.

2) On October 2, 2010, at 1:42 a.m., respondent removed 6 mg Hydromorphone from Pyxis. She did not chart administering or wasting it, or otherwise account for it. She did not chart a pain assessment before or after removing the Hydromorphone from Pyxis.

G. **Patient G**

1) On September 9, 2010, a physician ordered 2-4 mg Morphine every 3 hours as needed, starting on September 9, 2010, at 11:14 p.m., and ending on September 12, 2010, at 12:52 a.m.

2) On September 10, 2010, at 10:02 p.m., respondent removed 4 mg Morphine from Pyxis. At 10:02 p.m., she charted administering it. She did not chart a pain assessment before or after administering it.

3) At 11:11 p.m., respondent charted administering 4 mg Morphine. At 11:13 p.m., she removed 4 mg Morphine from Pyxis. She did not chart a pain assessment before or after administering it.

4) On September 11, 2010, at 1:58 a.m., respondent removed 4 mg Morphine from

Pyxis. At 2:05 a.m., she charted administering it. She did not chart a pain assessment before or after administering it.

5) At 6:19 a.m., respondent cancelled a transaction to remove 2 mg Morphine from Pyxis. At 6:22 a.m., she removed 4 mg Morphine from Pyxis. She did not chart administering or wasting it, or otherwise account for it. She did not chart a pain assessment before or after removing it from Pyxis. At 8:29 a.m., J.M.[2], R.N., charted that respondent administered 4 mg Morphine at 6:22 a.m.

H. **Patient H**

1) On September 13, 2010, a physician ordered 2-4 mg Hydromorphone every 2 hours as needed, starting on September 13, 2010, at 12:06 p.m., and ending on September 16, 2010, at 9:38 a.m.

2) On September 15, 2010, at 10:11 p.m., respondent removed 4 mg Hydromorphone from Pyxis. At 10:38 p.m., she charted administering it. She did not chart a pain assessment before or after administering it.

3) On September 16, 2010, at 2:19 a.m., respondent removed 4 mg Hydromorphone from Pyxis. At 2:29 a.m., she charted administering it. She did not chart a pain assessment before or after administering it.

4) At 2:43 a.m., respondent wasted 2 mg Hydromorphone. Approximately 30 seconds later, she removed 2 mg Hydromorphone from Pyxis. She did not chart a pain assessment before or after removing it from Pyxis. She did not chart administering or wasting it, or otherwise account for it.

I. **Patient I**

1) On October 27, 2010, a physician ordered 2-4 mg Morphine every 3 hours as needed, starting on October 27, 2010, at 7:54 p.m., and ending on October 28, 2010, at 5:48 a.m.

2) On October 28, 2010, at 2:41 a.m., respondent cancelled a transaction to remove 2 mg Morphine from Pyxis. Approximately 30 seconds later, she removed 4 mg Morphine from

[2] The nurses' names will be released pursuant to a discovery request.

Pyxis. At 2:41 a.m., she charted administering it. She did not chart a pain assessment before or after removing it from Pyxis.

J. **Patient J**

1) On October 22, 2010, a physician ordered 1-2 mg Morphine every hour as needed, starting on October 22, 2010, at 12:02 p.m., and ending on October 24, 2010, at 10:52 a.m.

2) On October 24, 2010, at 3:56 a.m., respondent removed 4 mg Morphine from Pyxis. She wasted 3 mg of it. M.R., R.N., signed as a witness to the waste. At 5:52 a.m., M.R. charted administering 1 mg Morphine at 4:00 a.m. M.R. charted a pain assessment before and after it was administered.

K. **Patient K**

1) On October 27, 2010, a physician ordered Oxycodone-Acetaminophen 5-325, 1-2 tablets every 4 hours as needed, starting on October 27, 2010, at 10:01 p.m., and ending on October 29, 2010, at 7:58 p.m.

2) On October 28, 2010, at 12:06 a.m., respondent removed 1 Oxycodone-Acetaminophen tablet from Pyxis. She did not chart administering or wasting it, or otherwise account for it. She did not chart a pain assessment before removing it from Pyxis. She charted the patient's pain was "8" at 1:00 a.m. She charted the patient's pain was "2" at 2:00 a.m.

L. **Patient L**

1) On November 5, 2010, a physician ordered Zolpidem 5 mg, 1-2 tablets every bedtime as needed, starting on November 5, 2010, at 5:14 p.m., and ending on November 11, 2010, at 9:40 p.m.

2) On November 5, 2010, at 10:29 p.m., respondent removed a 5 mg Zolpidem tablet from Pyxis. She did not chart administering or wasting it, or otherwise account for it.

M. **Patient M**

1) On November 10, 2010, a physician ordered 25 mcg Fentanyl every 3 hours as needed, starting on November 10, 2010, at 4:38 p.m., and ending on November 16, 2010, at 2:19 p.m.

2) On November 10, 2010, at 7:34 p.m., respondent removed 100 mcg Fentanyl from

Pyxis. She wasted 75 mcg of it. She did not chart administering or wasting, or otherwise account for, the remaining 25 mcg Fentanyl. She did not chart a pain assessment before or after removing it from Pyxis.

3) On November 20, 2010, a physician ordered 0.5-1 mg Hydromorphone every 6 hours as needed, starting on November 20, 2010 at 1:04 p.m., and ending on November 22, 2010, at 5:45 p.m.

4) On November 22, 2010, at 1:46 a.m., respondent removed 2 mg Hydromorphone from Pyxis. She wasted 1.5 mg of it. At 5:03 a.m., she late charted that she administered 0.5 mg Hydromorphone at 4:00 a.m. She did not record a reason for the late charting. She did not chart a pain assessment before administering it. She charted the patient's pain was "4" at 5:00 a.m.

5) At 6:09 a.m., respondent removed 2 mg Hydromorphone from Pyxis. She wasted 1.5 mg of it. She did not chart administering or wasting, or otherwise account for, the remaining 0.5 mg Hydromorphone. She did not chart a pain assessment after removing it from Pyxis.

N. **Patient N**

1) On November 6, 2010, a physician ordered 0.5 mg Morphine every 6 hours as needed, starting on November 6, 2010, at 11:18 p.m., and ending on November 17, 2010, at 3:42 p.m.

2) On November 11, 2010, at 4:03 a.m., respondent removed 2 mg Morphine from Pyxis. She wasted 1.5 mg of it. She did not chart administering or wasting, or otherwise account for, the remaining 0.5 mg Morphine. She charted the patient's pain was "6" at 3:51 a.m. She did not chart a pain assessment after removing the Morphine from Pyxis.

O. **Patient O**

1) On November 16, 2010, a physician ordered 1-2 mg Morphine every 4 hours as needed, starting on November 16, 2010, at 7:28 p.m., and ending on November 24, 2010, at 8:00 p.m.

2) On November 22, 2010, at 12:10 a.m., respondent removed 2 mg Morphine from Pyxis. She charted the patient's pain was "6" at 12:12 a.m. At 5:14 a.m., she late charted that she administered the Morphine at 4:00 a.m. She did not record a reason for the late administration or

charting.

3) At 5:24 a.m., respondent removed 2 mg Morphine from Pyxis. She did not chart administering or wasting it, or otherwise account for it. She charted the patient's pain was "5" at 5:00 a.m. She charted the patient's pain was "5" at 6:00 a.m.

P. **Patient P**

1) On November 5, 2010, a physician ordered 1 mg Hydromorphone every 6 hours as needed, starting on November 5, 2010, at 10:05 p.m., and ending on November 7, 2010, at 6:39 p.m.

2) On November 6, 2010, at 7:28 p.m., respondent removed 1 mg Hydromorphone from Pyxis. At 9:50 p.m., respondent late charted that she administered it at 9:06 p.m. She did not record a reason for the late administration or charting. She did not chart a pain assessment before administering the Hydromorphone. She charted the patient's pain was "0" at 10:06 p.m.

Q. **Patient Q**

1) On November 10, 2010, a physician ordered Codeine-Guaifenesin 10 ml every 4 hours as needed, starting on November 10, 2010, at 11:08 p.m., and ending on November 23, 2010, at 9:42 p.m.

2) On November 16, 2010, at 7:54 p.m., A.B., R.N., charted administering 10 ml Codeine-Guaifenesin. At 7:57 p.m., respondent removed 10 ml Codeine-Guaifenesin from Pyxis.

R. **Patient R**

1) On November 12, 2010, a physician ordered 1 mg Hydromorphone every 4 hours as needed, starting on November 12, 2010, at 4:21 a.m., and ending on December 1, 2010, at 5:39 p.m.

2) On November 17, 2010, at 9:01 p.m., respondent removed 2 mg Hydromorphone. She wasted 1 mg of it. She did not chart administering or wasting, or otherwise account for, the remaining 1 mg Hydromorphone. She did not chart a pain assessment before or after removing it from Pyxis.

S. **Patient S**

1) On November 16, 2010, a physician ordered 5-500 Hydrocodone-Acetaminophen

1-2 tablets every 6 hours as needed, starting on November 16, 2010, at 2:00 p.m., and ending on November 19, 2010, at 3:34 p.m.

2) On November 16, 2010, at 11:31 p.m., respondent removed 2 tablets Hydrocodone-Acetaminophen from Pyxis. On November 17, 2010, at 3:48 a.m., she late charted administering 2 tablets Hydrocodone-Acetaminophen on November 16 at 9:30 p.m. She did not record a reason for the late charting. She charted the patient's pain was "8" at on November 16 at 10:30 p.m. She did not chart a pain assessment after administering the tablets.

3) On November 18, 2010, at 5:46 a.m., respondent removed 2 tablets Hydrocodone-Acetaminophen from Pyxis. She did not chart administering or wasting them, or otherwise account for them. She did not chart a pain assessment before removing the tablets from Pyxis.

4) On November 17, 2010, a physician ordered 0.5 mg Hydromorphone every hour as needed, starting on November 17, 2010, at 7:48 a.m., and ending on November 18, 2010, at 7:16 p.m.

5) On November 18, 2010, a physician ordered 0.5-1 mg Hydromorphone every hour as needed, starting on November 18, 2010, at 7:15 p.m., and ending on November 19, 2010, at 3:34 p.m.

6) On November 18, 2010, at 3:38 a.m., respondent removed 2 mg Hydromorphone from Pyxis. She wasted 1.5 mg of it. She did not chart administering or wasting, or otherwise account for, the remaining 0.5 mg Hydromorphone.

7) On November 18, 2010, at 7:23 p.m., respondent charted administering 1 mg Hydromorphone. At 7:25 p.m., she removed 2 mg Hydromorphone from Pyxis. She wasted 1 mg of it. At 7:27 p.m., she charted administering 1 mg Hydromorphone. She charted the patient's pain was "6" at 7:49 p.m. She charted the patient's pain was "2" at 10:23 p.m. At 10:59 p.m., she late charted that 1 mg Hydromorphone was not administered at 7:27 p.m. She did not record a reason for the late charting.

8) On November 18, 2010, at 10:55 p.m., respondent cancelled a transaction to remove 2 mg Hydromorphone from Pyxis. At 11:00 p.m., respondent removed 2 mg Hydromorphone from Pyxis. She charted the patient's pain was "5" at 11:00 p.m. At 11:00 p.m.,

she late charted administering 1 mg Hydromorphone at 10:00 p.m. She did not record a reason for the late charting. She did not chart a pain assessment after administering it.

24. Respondent was interviewed on or about September 29, 2011. She stated that she understood the need and importance of charting pain assessments and medication. She stated that she did not follow the hospital policy for charting medications when the computer did not work properly, was not available, or she was in a hurry. She admitted that her charting looks "horrible and awful."

25. On or about October 31, 2011, respondent submitted a declaration dated October 25, 2011, in which she made the following admissions: "The situation at Stanford has been very difficult for me. I am embarrassed and disappointed in myself as a nurse. I take full responsibility for my actions and my charting errors; however, I can assure you that every medication I removed from the Pyxis was given to the patient for whom it was ordered. I admit that sometimes I would forget to chart the medications; there were instances where I was busy, and I intended to chart them later in my shift. There were other times that I would scan the medication in the patient's room and the computer would freeze or shut down, losing all the medications I had scanned. As a result, I would go back and chart by memory after giving the medication. I do realize this is not the correct way for charting medications, but at the time I felt I was doing the best I could."

FIRST CAUSE FOR DISCIPLINE
Unprofessional Conduct: Incompetence
(Bus. & Prof. Code, § 2761, subds. (a) & (a)(1)); Cal. Code Regs., tit. 16, § 1443)

26. The allegations of paragraphs 22-25 are realleged and incorporated by reference as if fully set forth.

27. Respondent has subjected her license to disciplinary action for unprofessional conduct under section 2761, subdivision (a), as defined by subdivision (a)(1) and California Code of Regulations, title 16, section 1443. As set forth in paragraphs 22-25 above, she was incompetent and lacked the possession of or failed to exercise that degree of lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed

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and exercised by a competent registered nurse by failing to follow hospital policy regarding pain management, and administration and documentation of controlled substances.

SECOND CAUSE FOR DISCIPLINE
Unprofessional Conduct: Gross Negligence
(Bus. & Prof. Code, § 2761, subds. (a) & (a)(1)); Cal. Code Regs., tit. 16, § 1442)

28. The allegations of paragraphs 22-25 are realleged and incorporated by reference as if fully set forth.

29. Respondent has subjected her license to disciplinary action for unprofessional conduct under section 2761, subdivision (a), as defined by subdivision (a)(1) and California Code of Regulations, title 16, section 1442. As set forth in paragraphs 22-25 above, she was grossly negligent by manifesting an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse including, but not limited to, failing to follow hospital policy regarding pain management, and administration and documentation of controlled substances.

THIRD CAUSE FOR DISCIPLINE
Unprofessional Conduct: Possession of Controlled Substance or Dangerous Drug
(Bus. & Prof. Code, §§ 2761, subd. (a); 2762, subd. (a))

30. The allegations of paragraphs 22-25 are realleged and incorporated by reference as if fully set forth.

31. Respondent has subjected her license to disciplinary action for unprofessional conduct under section 2761, subdivision (a), as defined by section 2762, subdivision (a). As set forth in paragraphs 22-25 above, she repeatedly possessed a greater or lesser amount of controlled substances or dangerous drugs than was accounted for by any record required by law.

FOURTH CAUSE FOR DISCIPLINE
Unprofessional Conduct: False, Grossly Incorrect, or Grossly Inconsistent Entries
(Bus. & Prof. Code, §§ 2761, subd. (a); 2762, subd. (e))

32. The allegations of paragraphs 22-25 are realleged and incorporated by reference as if fully set forth.

33. Respondent has subjected her license to disciplinary action for unprofessional conduct under section 2761, subdivision (a), as defined by section 2762, subdivision (e). As set forth in paragraphs 22-25 above, she made false, grossly incorrect, or grossly inconsistent entries

in hospital, patient, and other records pertaining to patient monitoring and the administration of controlled substances.

PRAYER

WHEREFORE, complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nurse License Number 733946 issued to Amanda Lynn Robbins;

2. Ordering Amanda Lynn Robbins to pay the Board the reasonable costs of the investigation and enforcement of this case pursuant to section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: November 2, 2012

for LOUISE R. BAILEY, M.ED., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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